ROLE CONFLICT AND REALITY SHOCK AMONG NEOPHYTE NAVY NURSES

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by

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TABLE OF CONTENTS

LIST OF FIGURES/TABLES iv

ABSTRACT 1

CHAPTER ONE: INTRODUCTION 3
STATEMENT OF PROBLEM 6
OBJECTIVES OF THE STUDY 7
ASSUMPTIONS AND LIMITATIONS OF THE STUDY 8
DEFINITION OF TERMS 8
ORGANIZATION OF THE STUDY 11

CHAPTER TWO: REVIEW OF LITERATURE 12
ROLE CONFLICT / ROLE AMBIGUITY 12
MOTIVATION AND STRESS IN RELATIONSHIP TO ROLE CONFLICT . 15
EXPECTATIONS VERSUS REALITY 17
REALITY SHOCK 20
PROFESSIONAL-BUREAUCRATIC CONFLICT 23
OCCUPATIONAL SOCIALIZATION: STATUS PASSAGE 27
CONCLUSION 30

CHAPTER 3: METHODOLOGY 32
DESIGN 32
SAMPLE SELECTION AND INSTRUMENT DEVELOPMENT 32
PROCEDURE 34

CHAPTER 4: RESULTS 36
INTRODUCTION AND DEMOGRAPHICS 36
ANALYSIS 39

CHAPTER FIVE: CONCLUSION/SUMMARY OF FINDINGS 62
SUGGESTED SOLUTIONS 65
IN THE NURSING SCHOOLS 65
HOSPITAL STAFF INSERVICE EDUCATION 65
NURSING MANAGEMENT 68
MENTORING 68
PRECEPTORSHIP 73
NURSE ADVOCATE OR STAFF COUNSELING SPECIALIST . . . 75
SUMMARY OF RECOMMENDATIONS 77
SUGGESTIONS FOR FUTURE STUDIES 79

APPENDIX A: QUESTIONNAIRE #1 81

APPENDIX B: QUESTIONNAIRE #2 84

SELECTED SELECTED BIBLIOGRAPHY 87

LIST OF FIGURES

		page
FIGURE 1:	Prior Nursing Experience	38
FIGURE 2:	Prior Military Background	38
FIGURE 3:	Job Relocation	40
FIGURE 4:	Support in Relocated Area	40
FIGURE 5:	Interest in Current Area of Assignment	41
FIGURE 6:	Experience in Current Area of Assignment	41
FIGURE 7:	Sponsor Assistance	43

LIST OF TABLES

page

TABLE A: Matched T-test of Comparing Identical Questions From Survey #1 to Survey #2 54

TABLE B: Summary (of Table A) Using Collective Combination of All Categorical Questions 54

TABLE C-1: Effects of Role Conflict, Role Overload, Role Ambiguity, and Role Support on Job Satisfaction (Questionnaire #1) 56

TABLE C-2: Effects of Role Conflict, Role Overload, Role Ambiguity, and Role Support on Job Satisfaction (Questionnaire #2) 57

TABLE D: Summary (of Tables C) Using Collective Combination of All Categorical Questions 58

TABLE E: Comparisons of Role Conflict, Role Overload, Role Ambiguity, and Role Support on Job Satisfaction in Prior-Service New Graduates and "Malcontents" to the Whole Group 61

ABSTRACT

This descriptive exploratory study looked at the problems of reality shock and role conflicts for new graduate nurses in a highly bureaucratic setting, i.e., the Navy Nurse corps. Following 21 new graduate BSN nurses from 2 weeks after reporting in to their first duty station (Naval Hospital, San Diego) to eight months later, the study looks at the new graduates expectations versus reality, school-to-work transition problems, dissatisfies and conflicts with both their professional as well as officer roles in the Navy Nurse Corps, and how these decreased, increased and changed throughout this period of time. The information was obtained using two questionnaires and both group and individual interviews two weeks and eight months into their professional adjustment. Specifically the evaluation tools measured over time differences and correlations between job satisfaction and role conflict, role overload, role ambiguity, role support. The results showed the following: (1) over time even though role conflict and role overload decreased, job satisfaction also significantly decreased; (2) the role conflict and role overload that did exist had a significant inverse relationship to the amount of job satisfaction the neophyte perceived (3) role support directly affected job satisfaction; (4) role ambiguity did not have a significant effect on job satisfaction.

The main problems found with this group of neophyte Navy nurses in their school-to-work transition can be summarized as: little or no help from a sponsor (lack of initial support), having 4-8 different preceptors during their first 6 weeks of orientation, lack of feedback during orientation.

This report concluded with solutions including initiating a mentoring program, improving the preceptor program, increased support from division heads and clinical consultants, continuation of a full time Nurse Advocate/Staff Counselling Specialist, and increased feedback during the neophytes first year of work.

CHAPTER ONE

INTRODUCTION

The new graduate nurse reports to her first job filled with dreams, aspirations, and enthusiasm for her first challenging work assignment. With this comes a strong desire to bring about change in the patient care delivery system. She is equipped with a high professional and low bureaucratic orientation, a basket full of "shoulds" and "ought to's," and a sack full of skills, techniques, and role specific behaviors. She also brings the potential for conflict due to naivete, lack of understanding of certain existing constraints, and no socialization skills for work-related values. She is a prime candidate for massive **role conflict** (Vredenburgh and Trinkaus, 1983). While this report focuses on the problems created and experienced by the new graduates in their **status passage** into the workforce, the hope is to shine a light on ideas for resolving or lessening the transition difficulties.

Marlene Kramer's theory and studies on **"REALITY SHOCK"** (Kramer, 1974), strongly influenced the framework which guides this study. Although published 18 years ago, the theories still hold fast today. Kramer states that the socialization experiences provided today by most schools of nursing with

their heavy emphasis on professionalism is quite different in content and process from the socialization the new nurse finds in most work settings. The professional socialization mode resembles childhood socialization with a strong emphasis on values (Bradby, 1990). The "shoulds" and "oughts" are taught with little or no emphasis on compromise or shortcuts necessary in the work world. The socialization strategies and patterns of the work world are primarily adult, with focus on how values are put to work in the context of less than ideal circumstances, such as staff shortages and emergencies. In the reality shock situation, the newcomer arrives in uniform with nursing license in hand and she is expected to be competent. When the newcomer does not live up to those expectations, disappointment, and denigration occur. Co-workers and employers show these feelings, which in turn escalates the reality shock conditions (Munrow, 1983).

The National Commission of Nursing Education estimated a yearly resignation rate among hospital staff nurses in their first year to approach 70% (Munrow, 1983). Some studies feel that unfulfilled expectations is the cause for the high turnover among inexperienced nurses (Burton and Burton, 1982), while others support the notion that role conflict contributes more heavily than any other factor to nurse attrition (Gaertner, 1982).

Health care organizations, in particular, have long been considered a prime context in which to investigate the problem;

nurses, in particular, are caught between conflicting demands that emanate from standards relating to their professional status and demands from their administrative position (Krayer, 1986). Nurses, of course, have no monopoly on school-to-work-transition difficulties. Literature from the business world, education, public school teaching, and engineering, recount problems new graduates encounter. These fields also experience almost a 50% turnover rate in their first year (Benner, 1975). Typically the college graduates did NOT leave their first job because of fringe benefits, salary, (or other Hygiene factors), but rather because they could not sufficiently adjust to the **role stress** and **role conflict**. Thinking the "grass is greener," they move on.

At the heart of the exodus of new graduates is the nurse's inability to convert the professional-bureaucratic (organizational) conflict (the basis of "reality shock") into growth-producing initiatives for herself. The newcomer is considered to have adjusted when she has molded her values with those of the working community. Rather than growth, what occurs is a fusion or absorption into the system producing stagnation, apathy, and perhaps most important, continued intolerance. If the nurse does not acquire organizational loyalty, she is usually perceived as a troublemaker or malcontent who express a great deal of dissatisfaction and disillusionment with her job and with nursing. If she elects the conformist route, discarding her professional values and wholeheartedly

identifying with the organization, she will become more and more intolerant of the next deviant, such as another new graduate with a value system that is different from the one that has been adopted.

STATEMENT OF PROBLEM

For the new graduate nurse, the reality of nursing practice differs dramatically from their expectations. Their nursing education stressed patient centered nursing care that demanded continuity of patient care. The student nurse's intellectual capacity as a decision maker, her responsibility for patient welfare, and her leadership potential are emphasized. In contrast, the hospital stresses bureaucratic principles, management of tasks to be achieved within a time frame, and standardized rules. For the new graduate it means a compromise between values in their nursing education and those of the bureaucracy of "real world" nursing. There is a sense of conflicting loyalties toward the bureaucratic and professional system of work organization, and a "reality shock" emerges. Unless the new graduate is assisted in resolving the conflicts or discrepancy in the values and norms they encounter, job satisfaction be difficult for them to achieve, and the nurse will either chose to become less professional with continued employment or will withdraw from the hospital work scene.

OBJECTIVES OF THE STUDY

The major purpose of this descriptive, exploratory study was to look at the problems of reality shock and role conflicts for new graduate nurses in a highly bureaucratic setting, i.e., the military. The specific objectives that guided the design and development of this study are as follow:

1. Determine the new graduate nurse's expectations of their first job as a Navy nurse and compare to reality;
2. Determine and describe the new nurse graduate's school-to-work transition and what problems are defined by the new graduates;
3. Determine the dissatisfies, stressors, and conflicts the new nurses encountered upon reporting to their first duty station in the Navy and track how these decrease, increase, or change throughout their first year of Nursing;
4. Determine to what extent role conflict, role ambiguity, and role overload, affect the new graduates' job satisfaction;
5. Determine if there is an inter-role conflict between the dual role of the nurse and a military officer;
6. Ascertain and describe recommendations of nursing service professionals and nurse educators for resolving school-to-work transition problems.

ASSUMPTIONS AND LIMITATIONS OF THE STUDY

For the purpose of the study, it was assumed that individuals interviewed and surveyed answered all questions honestly and openly. The results of this study cannot be generalized beyond this group of Navy Nurse Corps Officers due to the following limitations:

1. The number of new graduate nurses in this study (a total of 21), is only a small representation of all new nurses beginning their careers in Navy hospitals throughout the world;

2. Many of the nurses in the study, due to being prior-service corpsmen, had the advantage of increased socialization and perception of their new role due to prior exposure and experience in a military medical setting;

3. There is no way to determine the accuracy and honesty of the participants' answers.

DEFINITION OF TERMS

For a complete understanding of the review of literature to follow, it is necessary to make some concepts and terminology explicit.

ROLE is a set of expectations about how a person in a given position in a particular social system should act, and how the individual in a reciprocal position should act; these expectations include prescriptions of rights and duties. Role expectations have both an action and a cognitive component.

ROLE BEHAVIOR, the action component, is the observable action or behavior of an individual functioning in a given position in a social system.

ROLE CONCEPTION, the cognitive component, is the internal representation of the role expectation held by an individual at a specified time, including cognitions, values, anticipated maneuvers, and responses. Role conception can be further broken down in nursing to imply three main value systems:

1) **SERVICE ROLE CONCEPTION** is the nurse's "calling" -- the "angel of mercy" concept and is primarily altruistic and selfless in motivation.

2) **PROFESSIONAL ROLE CONCEPTION** refers to the occupational principles, role expectations, and role behaviors that transcend the location of specific employment; these principles and behaviors are inherent to all members of the professional occupation.

3) **BUREAUCRATIC ROLE CONCEPTION** refers to the rules, regulations, and procedures that describe and govern the nurse's job and role expectation in a specific employing organization.

ROLE DEPRIVATION is the disparity between idealized role conception and that which is found operable and sanctioned in the work situation.

ROLE CONFLICT is the simultaneous occurrence of two or more sets of pressures, such that compliance with one would make compliance with the other more difficult. In the context of this report, it is more specifically the incompatibility of

demands in the form of conflict between organizational demands and one's own values.

INTRA-ROLE CONFLICT occurs when two or more persons, or groups, expect the role occupant to act in contradictory ways.

INTER-ROLE CONFLICT results when a person has two or more roles which simultaneously require opposing behavior: ex: Navy officer, administrator, nurse.

ROLE OVERLOAD is a subdivision of role conflict. It is best defined as the incompatibility between work demands and the time available to fulfill those demands; the amount of pressure felt to do more work, the feeling of not being able to finish an ordinary days work in one day; the feeling that the quantity of work interferes with its quality.

ROLE AMBIGUITY is the lack of specificity concerning job responsibilities. It exists when information available (either quantity or quality) to an organizational member is inadequate or vague, or contradictory.

STRESS is the perceived dynamic state involving uncertainty about something important.

ROLE STRESS consists of psychological and physiological changes within people that derive from the interaction of people and their jobs and which result in deviations from normal functions.

STATUS PASSAGE is the socialization process where you have a life transition from one social status to another. This includes the anticipations and anxiety experienced prior

to the event as well as a "letting go" of some aspects of a previous status. It is often accompanied by feelings of bewilderment and being overwhelmed: a kind of reality shock.

REALITY SHOCK means the total social, physical, and emotional response of a person to the unexpected, unwanted, or undesired, and in the most severe degree -- the intolerable. In the context of this paper, it is the discovery that school-bred values conflict with work-world values. In some instances, reaction to the disparity is so strong that the individual literally cannot survive in the situation.

SELF-EFFICACY is a person's expectation that they can execute successfully the behavior required to produce a desired outcome; the mastery of role and organizational requirements to perform successfully in new situations.

ORGANIZATION OF THE STUDY

This study is presented in five chapters. Chapter One provides an overview of the statement of the problem, purpose of the study, and related definitions of terms. Chapter Two presents a review of literature relative to role conflict and reality shock in general and specifically in the Nursing profession. Chapter Three describes the methodology used in the study. Chapter Four presents the narrative and tabular analysis generated by the study. Chapter Five provides a summary of the study, a statement of conclusions, and recommendations.

CHAPTER TWO

REVIEW OF LITERATURE

ROLE CONFLICT / ROLE AMBIGUITY

Role conflict and role ambiguity are two of the most vigorously studied variables in modern complex organizations. With few exceptions, research shows that role conflict and role ambiguity produce negative consequences and dysfunctional results for individuals and organizations. Despite these findings, training and development has provided few specific training strategies for reducing role conflict and ambiguity among subordinates in an organization (Krayer, 1986).

It has been found that employees who reported high levels of role conflict and role ambiguity experienced greater tension, were less satisfied with their jobs, had a greater likelihood to leave the organization, and possessed numerous physiological maladies as compared with subordinates with lower levels of conflict and ambiguity (Krayer, 1986).

Nurses are frequently used in psychological studies of work-role stress for the following reasons: they are members of a profession working in bureaucratic organizations; they experience conflict about control growing out of incongruity between actual work practices and expectations implanted during training; they are struggling for increased professional recognition and prestige; they possess considerable

responsibility; they historically receive low pay; due to high nursing turnover, and a labor market characterized by high demand relative to short supply, some nursing positions are not filled resulting in overwork for hospital nurses (Vredenburgh and Trinkaus, 1983).

In a recent study (Bacharach, Bamberger, and Conley, 1990) of 800 nurses and engineers, the results indicated that role conflict and role overload are associated with different work process variables. This study found that managerial strategies appropriate for minimizing role conflict are NOT the same strategies that are appropriate and effective for minimizing role overload. They found the more bureaucratically structured the job, the lower the reported level of role overload. Managerial strategies that reflected more bureaucratic norms, such as increased routinization and formalization may even effectively reduce role conflict and role overload (Bacharach, et al., 1990).

In nursing, not only do professional values interfere with bureaucratic values, and vice versa, but both the bureaucratic and professional role conceptions interfere with traditional nursing or service values. Nurses must profess some devotion to patients, some loyalty to the employing organizations, and some dedication to the profession. It is this emphasis and priority of loyalties that constitute the specific role organization and give rise to potential conflict. This has been labeled by

Corwin as **"role deprivation"** and is felt to be the underlying cause of reality shock (Benner, 1984).

There is a potential role conflict specific to military nurses, due to their role as an officer as well as that of a nurse. A report on women West Point graduates that studied non-traditional roles suggested gender differences arise when the role demands of the officer conflict with other roles such as mothers and women (Yoder and Adams, 1984). Findings are consistent with other research on the role conflicts and stresses involved in breaking into non-traditional occupations. [Note it is traditional for a female to be a nurse, but not a military officer. On the other hand it is not traditional with a male to be a nurse, but the male nurses may more easily fit into the role of a military officer.]

The actual role of a military nurse may result in **inter-role conflict**, i.e., when the nurse simultaneously possesses more than one role that requires opposing behavior: Naval officer, administrator, nurse (Adams, 1988). The military nurse primarily provides patient care to military personnel and their dependents. They can experience conflict between their role as clinician, with emphasis on providing excellent patient care, and their role as a Naval officer, and the need for a physically ready, mobilizable Navy. It is often hard to deal with having nursing personnel leave the unit to take physical readiness tests, to practice for mobilization exercises, and to attend lengthy sessions on military

training, when patient census is high and patient care needs are numerous.

MOTIVATION AND STRESS IN RELATIONSHIP TO ROLE CONFLICT

Until recently, motivation of professionals was not considered to be a significant problem. In fact, professionals, by definition are supposed to undergo a lengthy and intensive socialization process that produces a high level of internal motivation (Chernis, 1984). With popularity of the idea of "professional burnout" that started during the late 70s and early 80s, motivation came to the surface as a significant concern.

Hall and Schneider (Chernis, 1984) found that the work experience the neophyte had during the first years of their career was associated with the levels of motivation and success attained in later years. In an in-depth longitudinal study by Cherniss where he interviewed lawyers, nurses, health professionals, and teachers, at different intervals during their first two years of employment, he found that work motivation of many new professionals declined during the first year or so. He more specifically observed: (a) a lowering of goals and standards when the professional felt their original expectations and professional goals were unrealistic; (b) a shift in causal attributions for success and failure--specifically, a tendency to blame the clients or the "system" for failure rather than

one's own methods; (c) a decrease in psychological involvement in work, where need fulfillment was sought outside the job (Chernis, 1984).

Another important finding was that the amount of motivational decline seemed strongly related to the degree of stress that the new professionals encountered with their jobs, i.e., the greater stress, the greater the motivational decline.

Stress is an intensively written about and studied topic, as it should be. Stress is related to physical and mental health, absenteeism, turnover, job dissatisfaction, work effectiveness and work withdrawal (Levinson, 1990). Stress exists when an individual perceives an environmental situation as presenting demands that threatens to exceed the individual's capabilities and resources for managing it. Two of the most important work factors related to stress are role conflict and role ambiguity (Zahrly and Tosi, 1988; Stout and Posner, 1984; Levinson, 1990). When either role conflict or role ambiguity is perceived, a worker experiences stress, since he feels unable to meet the demands of the work environment.

Four of the largest sources of stress are: (a) the high degree of ambiguity and conflict found in the goals and technologies of human service organizations. (b) professional-bureaucratic role conflict; and (c) the professional-client relationship; and (d) an absence of formal, organizational concern about the quality of work life of professionals (Cherniss, 1984). New professionals particularly are affected

by ambiguity because they have not yet proven themselves. They are apprehensive about how well they will do. As professionals they are expected to be extremely competent and so look for signs indicating whether or not they are. When signs are missing or unclear, resulting self-doubt can undermine motivation.

EXPECTATIONS VERSUS REALITY

For new graduate nurses, the reality of nursing practice differs dramatically from what they expected. One survey showed most new graduates expect: full-time work on the day shift of a medium-sized or large hospital; a good salary, pleasant working conditions and the opportunity to work in their desired specialty; and to be promoted to a supervisory position in less than three years (Burton and Burton, 1982). What nurses want most is self-fulfillment and a sense of achievement or accomplishment (Burton and Burton, 1982), Maslow's "self actualization." They need recognition and encouragement. Nurses feel guilty if they are unable to give patents adequate and complete care.

For most nurses, "real" nursing is synonymous to bedside care. Nurses bring this image into nursing school, and often even the schools cannot dislodge it when they try. In the work situation, the nurse is actually required to perform four major types of duties: technical, administrative, organizational, and

educative. Consequently there is a sharp disparity between the job the nurse expects to perform and the actualities of her work.

In a New Zealand study, the new graduate nurses experienced major conflicts and frustrations resulting from the emphasis given to the physical aspects of patient care and to technical skills (i.e., the tasks). They experienced little or no continuity of patient care and minimal opportunity to follow through the outcomes of their nursing care. In general, adjustment meant the acceptance of nursing as a management of tasks. The nurses felt unable to alter the situation and accept the reality of the environment in which they worked. With the acceptance came dissatisfaction and a sense of guilt (Horsburgh, 1989).

This descriptive research of nursing in a foreign country reported many adjustment problems and conflicts between what new graduate had been trained for, their expectations, and the reality of hospital work on their first job. These same themes are also found among the new graduate nurses in the United States (Horsburgh, 1989). The first theme concerns the differing value systems surrounding nursing practice: those concerned with the beginning nurses's educational preparation, and the reality of actual nursing practice.

Kramer goes on to suggest that unless new graduates are assisted to resolve the conflicts or discrepancy in the value and norms they encounter, not only will job satisfaction be

difficult for them to achieve, but they will adopt the work values resulting in a kind of avoidance behavior or adoption of the status quo.

Another theme shows that there is a change from the predominantly formal mode of learning encountered within the school of nursing to an informal mode of learning within the initial employment setting; much of the pressure of the orientation program was on fitting into the bureaucracy. [Note Kramer described three major problems that relate to new graduate nurses' initial employment socialization period: first making a shift from formal to informal leaner roles; second, the nurse is confronted with inadequate feedback on performance; third, because the reality experience may be so great, the new graduate may be unable to assimilate and perceive many of the socialization messages (Kramer, 1974).]

A third theme is the lack of any identifiable component in the role of a staff nurse that differs from any other qualified nurse. In reality the practice was determined by such context effects as the time of the shift and the availability of experienced nurses. [Note: no other professional group expects their practitioners in first positions to supervise students and other levels of staff. Yet new graduates are made responsible for not only their own activities but those of others.]

REALITY SHOCK

No two persons experience reality in the same way. Marlene Kramer's research and coining of the phrase "reality shock" in reference to new graduate nurses has become the foundation of much research since her initial publications over 18 years ago. Kramer found that the shock comes in four stages or phases (Kramer, 1974):

1) The "honeymoon" phase is the first reaction when a person enters the work setting with an awe of fascination. [Note that frequently in-service educators even increase this by buffering the reality of work for the new graduate.] In this cocoon, the new world of nursing looks rosy. The honeymoon is in full swing when the new graduate picks and chooses the parts of the new culture that are fascinating to her. However, soon familiar cues such as rewards, sanctions, and role behaviors are lost and the honeymoon phase is over.

2) Shock and rejection set in as the new graduate comes into daily contact with conflicting values and ways of doing things, things for which appropriate skills, interpersonal cues, and responses are lacking. This is a crucial phase: if conflict resolution does <u>not</u> occur at this point, then progress toward self-discovery and growth will be arrested.

In the shock and rejection phase, reactions vary but there is usually some form of rejection. The neophyte nurse may feel

bitterly toward the strange culture and reject all parts of it. Coupled with rejection, there is often regression.

Another form of rejection is against oneself. The neophyte may feel she is a failure, that she cannot possibly make good, and that all the money spent on her education was wasted. She blames herself for every mistake and feels defeated when she is not an overnight success in everything.

Also prevalent in reality shock is a rejection of the sending agency that "got me into this in the first place." This also can be seen in the bitterness and feelings of betrayal when they speak of their formal professional education.

Other signs and symptoms in this phase are: protective isolationism (withdrawal, banding together and dependence on others who hold the same values) and hostile or aggressive attitudes. Frequently the feelings of anger and hostility are accompanied by messages of "how things should be," or "how we were taught to do things in school." The neophyte may be shocked by the degree to which the "good ideas" were rejected, the way that they were undermined, sidetracked or even sabotaged. The neophyte is often closed and unable to hear and perceive cues and messages sent her way.

The physical responses to the shock, anger, hostility, and frustration of this rejection phase of reality shock, as well as the tremendous amount of energy needed to communicate one's own message, leads to another symptom common to this phase: excessive fatigue and illness. Although anger may be expressed

through overt aggression, depression and withdrawal to one's bed appear to be the more predominant behavior in reality shock. (Such statements as "I went home from work and slept around the clock ... I just can't seem to get enough sleep" etc. are common in this phase.)

3) RECOVERY STAGE: A beginning sense of humor is the first sign of the recovery phase. There is less tension, and an ability to see the amusing side of things, along with a beginning ability to weigh, assess, and objectively evaluate aspects of the new work culture. There is an increasing competence to accurately predict the action and reaction of others in situation. As new cues are learned and assimilated, the signs of tension are gradually removed and the blinders that prevented clear and open perception lifted. Self discovery is the beginning of healing, and not only enables the individual to grow more fully as a person, but also permits him to meet work expectations of the new culture.

4) RESOLUTION STAGE: Since working hours do not make up the whole of one's existence, resolution is sometime postponed as it is easier to run away from the shock producing conflict. There is a continual hope that "things will get better" or that somewhere the perfect situation exists, (therefore the rapid turnover of nurses). Frequently unequipped with knowledge, skills, and the social power to bring about change on the new job, the neophyte's unfulfilled hope generates continued frustration and despair.

PROFESSIONAL-BUREAUCRATIC CONFLICT

Professional-bureaucratic conflict is not new, nor is the problem unique to nurses or to society. No profession has escaped the advancing tide of bureaucratization. In the last 20 years, there has been an increasing awareness and study of the conflict experienced by professionals employed in bureaucratic settings, and the adaptations of both man and the organizations to the conflict.

Bureaucracy and professionalism represent two different and potentially conflicting modes of social control. Specifically, the professional system relies on a lengthy and arduous period of socialization and regulation by peers. Professionals are granted a great degree of autonomy. Their first priority and responsibility is to the patient, and quality of care comes above cost-containment or uniform treatment.

In the bureaucratic system, the emphasis is on external control by a superior, and development of specific rules and procedures, all of which infringe on the autonomy of the individual worker. Bureaucratic mechanisms are necessary to coordinate the activities of diverse groups of workers to insure that they continue to remain within certain limits and get the job done. But to the professional, these control mechanisms and priorities are experienced as hindrances and are often seen as violations of one's professional rights and privileges (Cherniss, 1984). Unless the neophyte anticipates these constraints and possesses methods for coming in terms with them,

the resulting tension, conflict, and hostility, will significantly undermine the new professional's motivation.

Employees in professional settings, such as hospitals, frequently violate the formal administrative hierarchical chain of command in role conflict producing situations (Krayer, 1986). Multiple authority disrupts the individual's orientation to his organization or profession by requiring him to choose between the two. Individuals oriented primarily toward their professional norms are more critical of the organization and are more likely to ignore administrative details. As a result, professionals in such organizations frequently experience stress because of being caught in the middle.

Kramer gives further insight of the professional-bureaucratic conflict in terms of two conflicting work systems: whole-task and part-task (Kramer, 1974):

In the whole-task work system, the worker possesses all of the necessary knowledge and skills to do the total job. The scope of the knowledge and skills needed is extensive and broad, and requires considerable time to acquire them, (usually in an educational institution before employment.) Since the individual worker completes the entire job, coordination of tasks and external controls are not needed; internalized coordination and standards of performance, norms, or codes of ethics are employed.

In contrast, in the part-task system, the task is segmented, with only a few skills needed. These skills are

usually learned on the job in a relatively short period of time, and the organization teaches the worker how to do them exactly the way they want them to be done. The worker repeats the same task frequently and therefore has the ability to develop tremendous skill and speed in the performance of the tasks. His work output can easily be judged in terms of the units completed. There is normally some kind of external controls and coordination, usually in the form of rules and supervisory officials, set up to ensure the success and efficiency of the total operation. The workers are usually very loyal to the organization.

The problem, in respect to reality shock occurs because the student nurses are socialized into performing and expecting others to perform according to the professional whole-task system. Yet as employees in the work world, it becomes all too obvious, that this is not the way in their work is organized. Most nursing care today is organized on a bureaucratic part-task basis: the nurse gives medications, the Licensed Vocational Nurse (LVN) gives treatments, and the Nurse's Aid (NA) gives baths and takes temperatures. It is rapid and efficient completion of part-tasks, or the successful grouping or coordination of part-tasks by other workers that the nurse is recognized for and then organizationally promoted.

Kramer identifies four areas of conflict that arise because of the different organizational principles of the professional and bureaucratic systems with respect to "task" (Kramer, 1974):

1)Professionals' resistance to bureaucratic rules. Bureaucratic systems require rules to decrease the amount of time needed to coordinate and supervise the component tasks of individual employees. Professionals are trained to use individual judgement rather than established rules to coordinate and execute the component tasks in rendering service to their clients. When professionals are employed by bureaucratic organizations, some degree of autonomy must be sacrificed because they do not possess the requisite skills for doing the entire task of the complex organization. Since this is contrary to the professional's orientation, it is likely that the professional employee will resist established rules, favoring their internalized professional norms.

2. Professionals' rejection of bureaucratic standards. The standards of the bureaucratic system are based on skills and precision in the execution of a defined and limited task with emphasis on the "concretely possible" and the proven way of doing things. Professionals' standards are based on present knowledge, are flexible, and constantly subject to change -- with emphasis on the "potentially possible" and innovative ways of doing things. So when a professional transfers from the learning to the practicing setting, he is likely to experience a conflict in standards.

3. Professionals' resistance to bureaucratic supervision. The bureaucratic system exists and functions on authority of positions, while in the professional system authority stems from

knowledge and competence. Most studies identify this problem of authority as the primary source of professional-bureaucratic conflict.

4. Professionals' conditional loyalty to the bureaucracy. The bureaucratic systems thrive on and rewards its members for loyalty to the institution. The professional system provides loyalty to its behavioral expectations. Since the two loyalties are often opposed, professional workers may tend to view the organization as a short-term instrument of personal actualization, and therefore only render conditional and temporary loyalty.

OCCUPATIONAL SOCIALIZATION: STATUS PASSAGE

Socialization is a reciprocal process by which neophyte nurses learn what others will demand of them in a specific role, and in turn learn how to exert control over their new environment (Myers, 1982). A distinction should be made between the school and the work world of nurses. School minimizes the practical skills and maximizes the ideals of nurse practice. Work minimizes the ideal and maximizes the practical art and skill of nursing. Kramer feels that in moving from one subculture to another, it can be expected that the new graduate will encounter difficulty in socialization in their first year of work. The professional socialization mode resembles the childhood socialization with a strong emphasis on values. The

socialization strategies and patterns of the work world are primarily "adult" with less emphasis on the "shoulds and ought to's" and more focus on how the values will work in the less than ideal circumstances such as staff shortages and emergencies (Kramer, 1974).

According to the theory of Van Maanen and Schein, (Jones, 1986), newcomers respond to their role differently because the socialization used by the organizations shapes the information newcomers receive. Role orientation is only one outcome that the process of socialization may influence. Other outcomes of importance and concern include: levels of role ambiguity and role conflict, job satisfaction, commitment, and intention to quit. These outcomes generally describe newcomers personal adjustments to their organizations.

During the occupational **status passage**, subpassages are also being negotiated: serial, disjunctive, divestiture (a subtle degradation), and collective or group passages (Bradby, 1990), as described below:

Serial passage refers to the method by which institutions train individuals by passing on specific skills from one generation to another. While the role model and the "way we do it here" approaches can be an excellent method of transmitting skills and the culture of the institution, it also can result in outmoded or poor practice. Conformity to the accepted norms is encouraged at the expense of developing ideas. Serial passage is at its best when a neophyte is shown by trained staff to

comes to term with death, or how to cope with demanding patients. This method of transmitting skills and the nursing process is exemplified throughout the "mentor system."

Disjunctive passage refers to those situations that the individual negotiates without help or guidance. Although this will occur normally in some situations, for example, undertaking research, for the neophyte nurse it also occurs when she undertakes providing most of the patient's essential care. An assumption is made that because she is "licensed," the neophyte should be able to perform nursing care without help.

Divestiture is the attempt of the organization to strip the individual of her identity so conformity with the institution's needs will occur. The armed forces offer a clear example of this process. Research suggests that undergoing such a process that is difficult and sometimes degrading. However, once achieved, the process will ultimately help the person feel part of that institution and increase self-esteem and personal competence. Divestiture is not advocated generally in most situations, but increasing a person's feelings of being welcomed and important to the institution is a common outcome. In one descriptive study (Bradby, 1990), they found that many students felt the need to establish a personal identity that had been lost during the rapid transition from a previous social status; they needed to find their place within a new geographical location, a new job, within the new peer group. Feeling part of the ward team was far more important than the quality of care to

be offered to the patients. They often made references as to the importance of having the ward staff like them and whether they could get along with them as people.

Collective passage refers to a group of people who start a course, job, or activity together and likely gain support from one another, i.e., are "in the same boat."

Occupational role identity usually occurs between six to ten months after entry into the new career (Bradby, 1990). For nurses most feel more comfortable with their clinical area and have grasped the theoretical concepts by the six month mark. Often for nurses, occupational socialization also hastens their status passage into the adult role due to the independent nature of their job.

In summary, entering an occupation for the first time or after a period of absence from work is an example of status passage. At the same time many younger entrants are also negotiating the status passage into adulthood that may even be more important to them. For most neophytes, searching for her personal identity is the most important factor before she can focus on her occupational role.

CONCLUSION

The causes and effects of role conflict and reality shock among professionals is complex. There is no simple or single explanation or solution. Kramer's studies founded the basis for research on the problem 18 years ago. Her theories on the

stages of reality shock and the conflicts of the new nurse, are studied in today's nursing schools. Yet the problems still exist. The subject is still being written up in research articles in nursing, business, and psychology journals all concurring on the devastating results of the conflict and shock: job dissatisfaction, job stress, job stagnation and apathy, high job turnover, and even a permanent exodus from the professional's job.

CHAPTER 3

METHODOLOGY

DESIGN

This study was designed to gather information about the role conflict and reality shock experienced by new graduate nurses entering the Navy. The aim of this descriptive study was to follow a group of neophyte nurses through their first eight months in the Navy, and to elicit information on their initial adjustment problems in a large Medical Center setting. The researcher was seeking to obtain data on whether there was possibly more role conflict in comparison to civilian RN's due to the Navy Nurse wearing "two hats," i.e., not only having to adjust to being a new nurse, but also having the role adjustment of being a new Naval Officer. The ultimate goal of this project was to seek information to better prepare future junior Navy nurses by proposing suggestions for orientation, preceptor and mentorship programs, and other solutions with hopes of easing the initial adjustment, promote job satisfaction, and as a long term goal, to increase retention.

SAMPLE SELECTION AND INSTRUMENT DEVELOPMENT

This study was conducted at the Naval Hospital, San Diego, California from October, 1991 to May, 1992. All 21 of the participants were active duty Nurse Corps Officers who had just

"reported aboard" as Ensigns between the months of August and September, 1991. All had recently graduated (within six months of the study) from their nursing programs, and had just completed the Navy's six week Officer Indoctrination School (OIS).

A questionnaire [Appendix A], designed by the researcher, was given to all 21 at the end of their second week of "formal orientation" to Nursing Service. The first part consisted of 30 specific questions (multiple choice using a one to five Likert scale and short answer) relating to role ambiguity, role conflict, role overload, role support, and job satisfaction. There were also several questions requesting background/ demographic information. A second questionnaire [Appendix B] was given at the conclusion of this study at the eight month mark. This questionnaire contained all of the multiple choice questions from the first one, plus several additional questions relating to the topics of role ambiguity, role conflict, role overload, role support and job satisfaction. The background/ demographic questions were not repeated.

Each participant was interviewed as a "group" during their eight week orientation and individually interviewed eight months after "reporting aboard." In each interview, the participants were again asked many of the same questions they had responded to in the questionnaire, but encouraged to expand on their answers. Individual confidentiality was promised for both the questionnaires and the interviews, and each participant was requested to be open and honest.

PROCEDURE

The procedure for this study consisted of three phases. The first phase consisted of obtaining permission to distribute the questionnaires and conduct interviews with the new Navy nurses. Permission was first elicited by coordinating with the Education and Training Department as well as with the Nursing Staff Counselling Specialist who discussed the proposed research with the Director of Nursing Service (DNS) at Naval Hospital, San Diego. [Note the Nursing Staff counselling Specialist's role at Naval Hospital, San Diego (NHSD) is discussed further in this report's conclusion (Chapter 5).] The researcher met again with the Nursing Staff Counselling Specialist in September, 1991, and questions for the questionnaire were discussed and designed.

The second phase began when the researcher met for the first time with the group of new nurses as a whole in their orientation in October 1991. Their names and phone numbers were obtained, and each "volunteer" orientee filled out Questionnaire #1. The researcher met with the entire group together two more times during their orientation. At these meetings the Nursing Staff Counselling Specialist facilitated the group session, encouraging the new nurses to discuss any problems they were having on orientation. The researcher sat in as an observer writing down problems as they were discussed. At the end of the participant's formal orientation, on December 10, 1991, the researcher met with about half the participants who showed up

for their last meeting as a group, again discussing problems, problem resolutions, adjustments, etc. They were informed that the researcher would be contacting them again between April and May of 1992 to follow up with the second and final questionnaire.

In the third phase, the second questionnaire was administered and individual interviews were conducted in person and via telephone to expand on the data collected from the questionnaires. This was done in May, 1992 to compare perceived problematic differences over time (their first month of being a nurse new to the profession and to the Navy and then after eight months) of the orientee's adjustment cycles. The participants were also asked for suggestions of changes and things that could have been done differently to decrease or eliminate their individually experienced role conflicts, and to increase their initial job satisfaction. The researcher elicited (via the telephone) advice on the best method of data interpretation with the Nurse Researcher at the Naval Hospital during third phase. An experimental psychologist was hired to do the statistical analysis for Chapter Four.

CHAPTER 4

RESULTS

INTRODUCTION AND DEMOGRAPHICS

These results are based on two confidential questionnaires and private interviews with 21 new graduate and new-to-the-Navy nurses from Naval Hospital, San Diego. The questionnaires, as described in Chapter 3, asked questions from five categories that were intermixed: job satisfaction, job support, role conflict, role ambiguity, and role overload. Interviews were done in order to allow the participants to expand on some of the "short-answer" questions from both of the questionnaires. All answers and comments kept confidential.

From Questionnaire #1 [Appendix 1], the following background information was elicited from the participants of this study: [Note: the word "histogram" followed by "x" and a number, indicate the figure #, for example, histogram x-1 matches with figure 1; also the number following indicates the questionnaire # as well as the question #, for example, 1-15 indicates the first questionnaire and the 15th question.]

PRIOR NURSING EXPERIENCE: [See Figure 1 /Histogram x-1 1-15]

10 (47.6%) indicated they had had no prior nursing experience

6 (28.6%) indicated they were prior service Corpsmen

3 (14.3%) indicated they had less than three months experience*

2 (9.5%) indicated they had over 1 years experience*

[* Note, when questioned in the interviews, these two groups had had prior experience working as student nurses or Licensed Vocational Nurses (LVNs) but not as a licensed Registered Nurse (RN); two had worked as RN's on their "interim" permit from graduation in May/June of 1991 until August of 1991 when they departed for O.I.S. But for the purposes of this study, they are still considered "new graduates" or neophyte nurses.]

PRIOR MILITARY EXPERIENCE: [See Figure 2/ Histogram x-2 1-16]

10 (47.6%) indicated "yes" they had a familiarity with the military [Note above that six were prior service corpsmen, One other was prior-service non-corpsman, and three were either prior dependent children or prior dependent spouses of military.

11 (52.4%) indicated no prior military experience or familiarity.

FIGURE 1: PRIOR NURSING EXPERIENCE

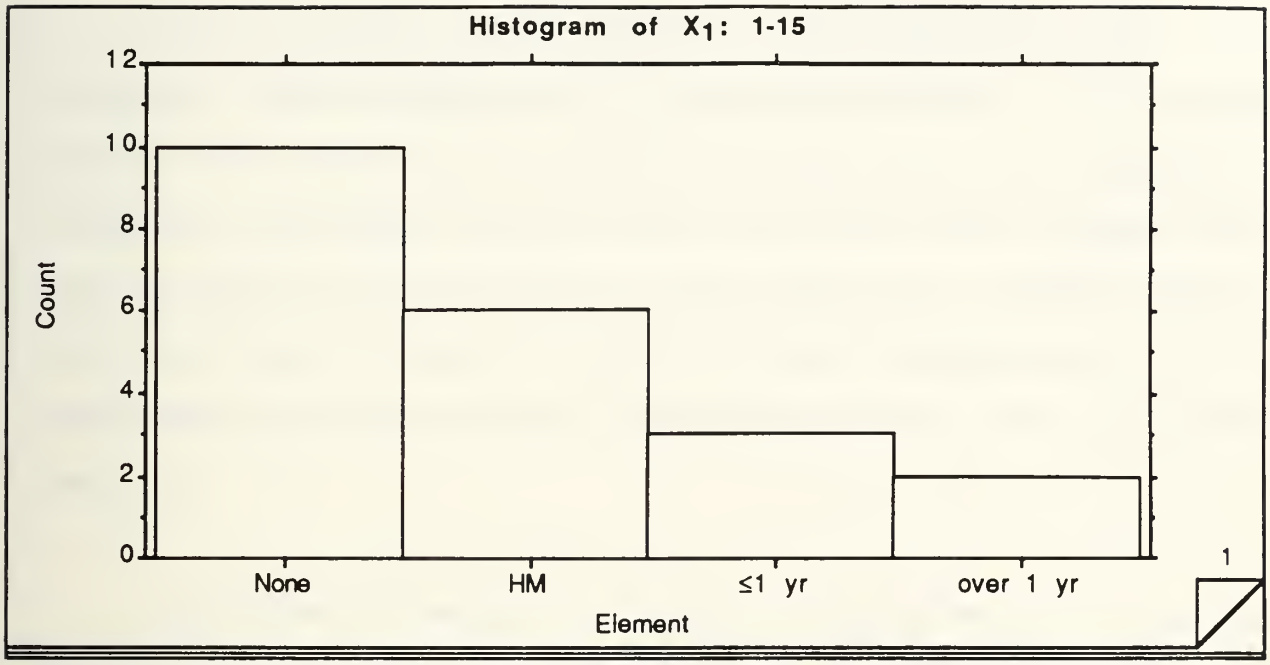
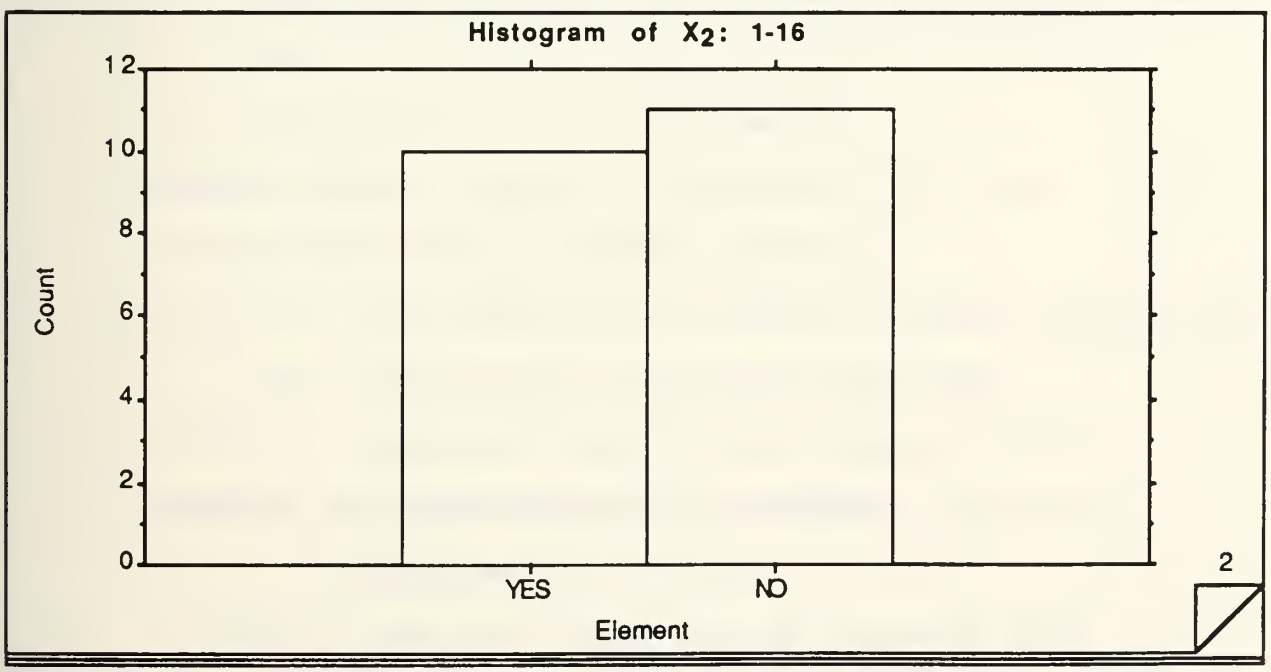


FIGURE 2: PRIOR MILITARY BACKGROUND



ANALYSIS

Before looking at the effects of ROLE CONFLICT, ROLE OVERLOAD, AND ROLE AMBIGUITY on JOB SATISFACTION, I will relate some of the results of the questions concerning the neophyte's stressors and support systems which also may have affected her job satisfaction both negatively and positively (respectively). The below results were all from the **first** questionnaire, i.e., asked when the new nurse was on orientation and had just started working.

RELOCATION (stressor): [Figure 3/ Histogram x-3, 1-17]

19 (90.5%) indicated they had to relocate from another geographical area to start their first job in the Navy.

2 (9.5%) did not have to relocate.

SUPPORT SYSTEM: [Figure 4/ Histogram x-4, 1-18]

Of those that had to relocate (above),

11 (57.9%) said they had no friends or family locally, or prior familiarity to the San Diego area

8 (42.1%) indicated they did have support in SD

INTEREST IN CURRENT AREA OF ASSIGNMENT: [Figure 5/ Histogram x-5, 1-19]

16 (76.2%) indicated their current (initial) work assignment was in an area of interest or where they had requested to work;

5 (23.8%) indicate it was not an area of interest.

FIGURE 3: JOB RELOCATION

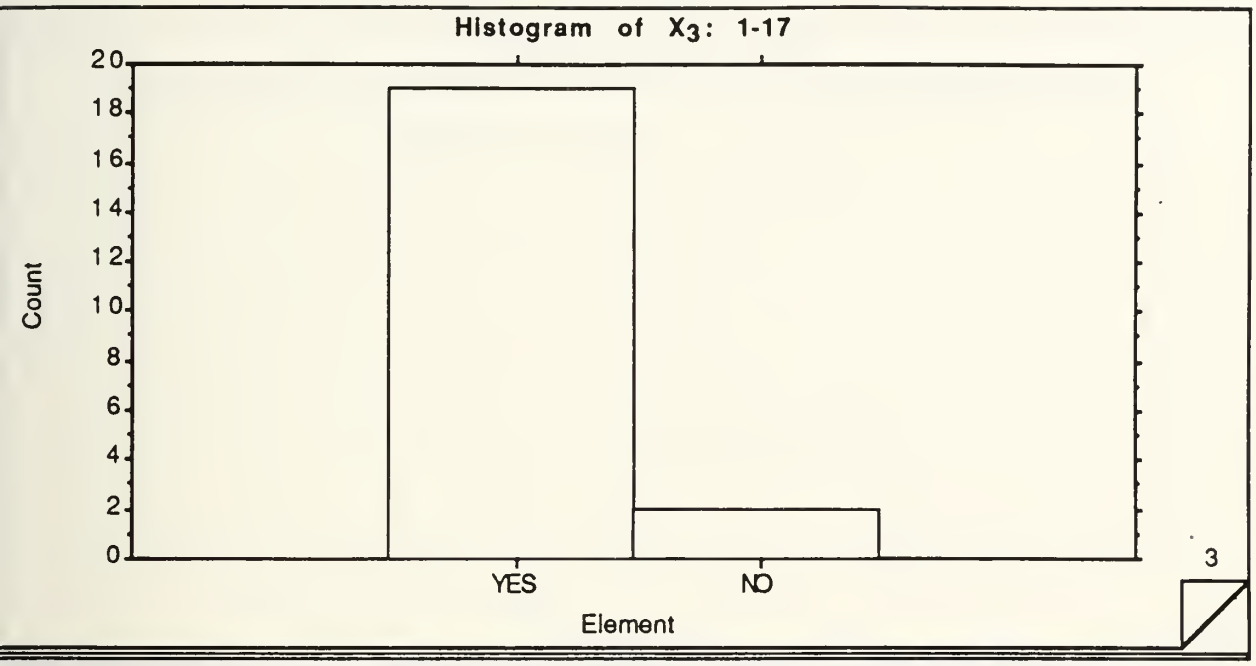


FIGURE 4: SUPPORT (FAMILY/FRIENDS) IN RELOCATED AREA

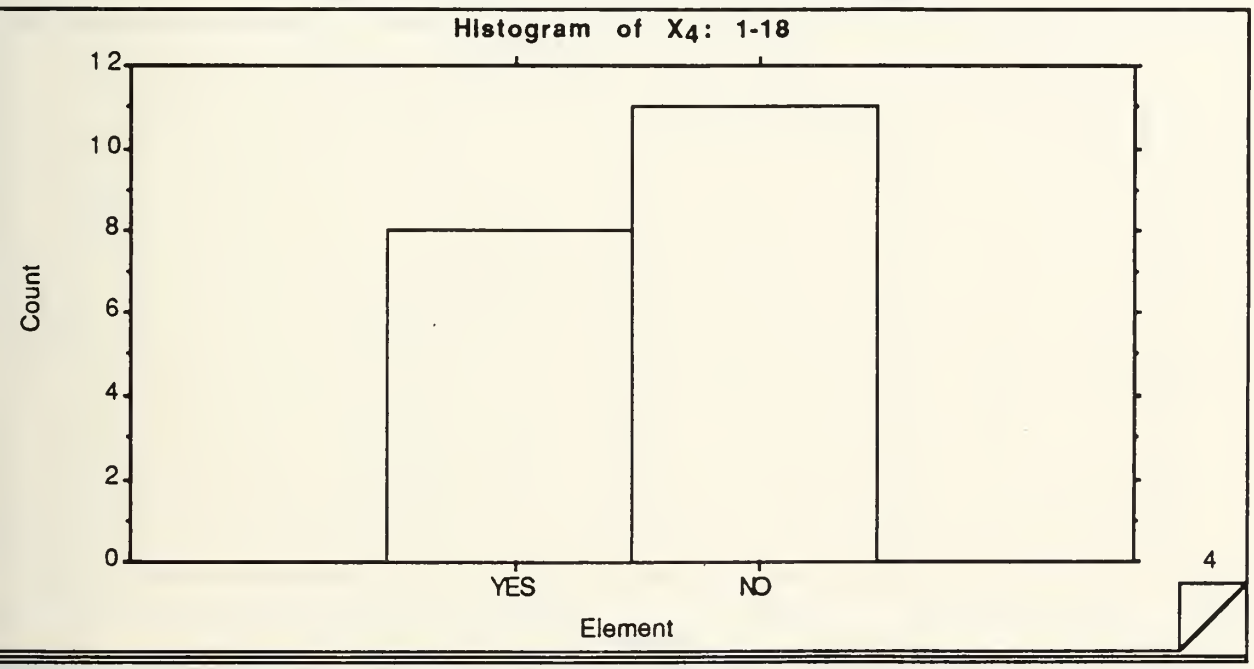


FIGURE 5: INTEREST IN CURRENT AREA OF ASSIGNMENT

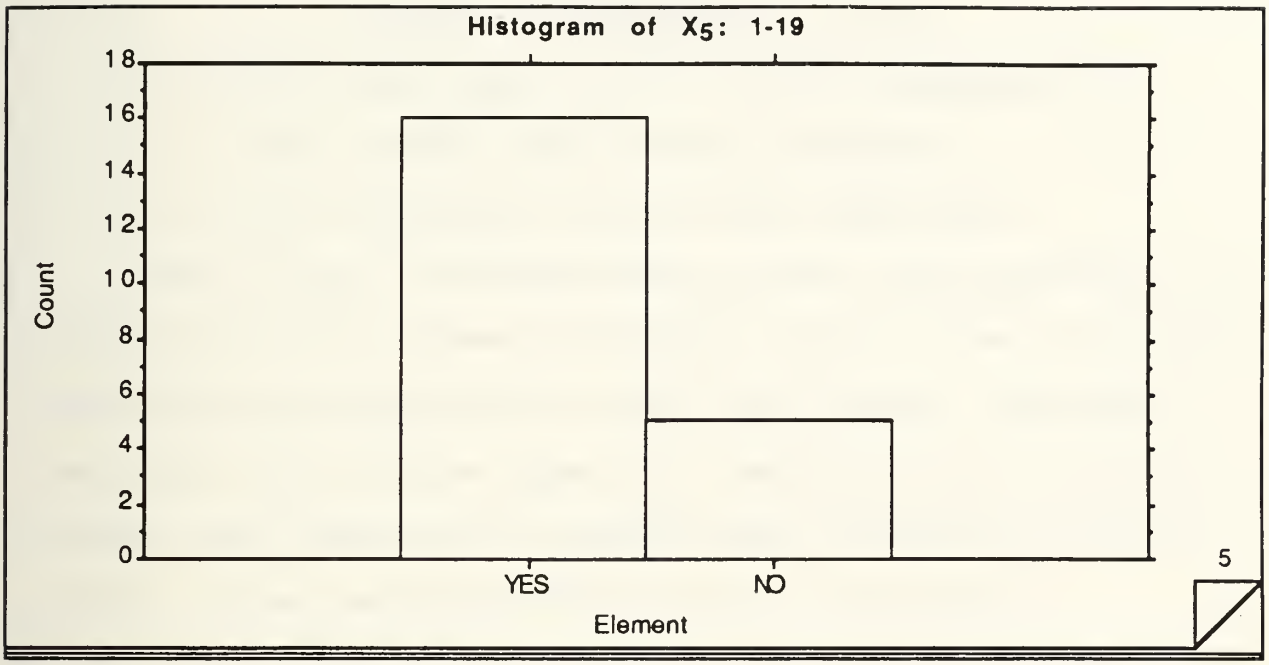
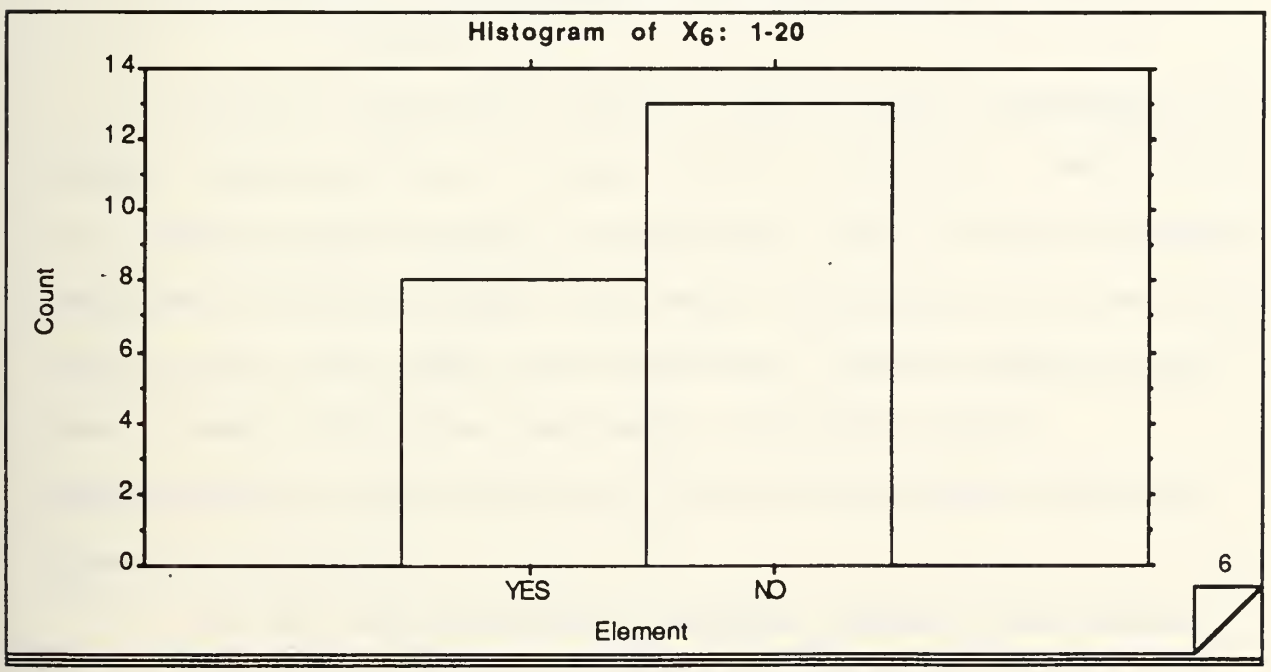


FIGURE 6: EXPERIENCE IN CURRENT AREA OF ASSIGNMENT



EXPERIENCE IN CURRENT AREA OF ASSIGNMENT (stressor)

[Figure 6/ Histogram x-6, 1-20]

13 (61.9%) indicated they did not have experience in their current area of work assignment;

8 (38.1%) indicated they did have experience.

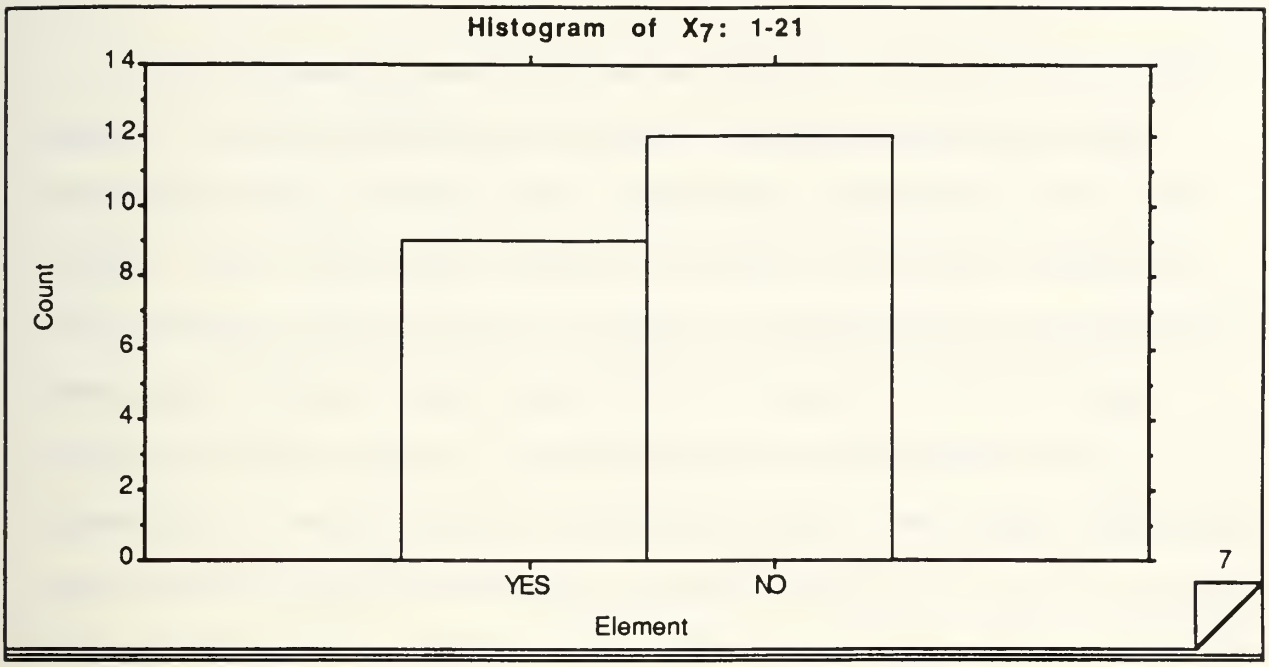
[Note: this, retrospectively was not a good question, as since noted above, these participants are all "new to nursing", their RN experience would be none in all areas. Those who indicated they **did** have experience, were familiar with their current work areas due to nursing school rotations or prior student nurse, nursing assistant (NA), or LVN jobs.

SPONSOR ASSISTANCE (support) [Figure 7/ Histogram x-7, 1--21]:

12 (56.1%) indicated they did **not** have the assistance of a sponsor before arrival to their new duty station; [Note, that in interviews and comments, some stated they did have a sponsor assigned, but that he/she, even when contacted by the new nurse, did not give them asked for assistance; others indicated that even 2 weeks after they had begun orientation (when questionnaire #1 was filled out) they did not know who their sponsors even were.]

9 (42.9%) indicated their assigned sponsors had gotten hold of them and had offered assistance.

FIGURE 7: SPONSOR ASSISTANCE



The following questions were asked in the form of "short answer" on the **SECOND** questionnaire administered and then repeated orally in the short interviews conducted with each nurse. As in the above section, these also cover aspects of role support and stressors possibly affecting job satisfaction. They also include some questions on conflict and overload. Finally in this section, intermixed with the above, were questions in which advice from the nurse is elicited concerning what "could have been done" to help them more, i.e., to increase their initial job satisfaction. The answers are summarized and commented on as follows:

1. WHAT <u>COULD HAVE BEEN DONE</u> TO HELP YOU MORE IN ADJUSTING TO YOUR FIRST FEW MONTHS AT YOUR NEW COMMAND?

* The most frequent response (stated directly by 25% of the respondents) was a **sponsor**. As noted from above, 56% said they never heard from their sponsor, weren't assigned one, or that their sponsor was of little or no help.

* Also the **preceptor** system was not ideal with 60% indicating they had 4-8 **different** preceptors assigned to them during their orientation period. [Note also though below where many stated their preceptor was the MOST influential person helping them in their adjustment.]

* Several indicated [and I regret not having asked this as a question to all of them] that they received NO formal and very little informal **feedback** during their orientation. The comment was made that "I had no idea how I was doing until I received

my first FitRep." [Note: this is referring to a fitness report, the form of written formal evaluation given to all naval officers annually (or semi-annually).]

* Other miscellaneous suggestions included: hold classes during orientation on: medications, Civil Service (civilian) workers (including how civil service works and their job descriptions, rules and regulations VS military), introduction to computers used in clinical areas, skills lab, and more time orienting to the role of team leader.

2. WHAT HAVE BEEN SOME OF THE HARDEST THINGS YOU HAVE HAD TO ADJUST TO IN YOUR FIRST 7 MONTHS AT NAVAL HOSPITAL SAN DIEGO?

* The most frequent response (25%) was being away from family, friends and their support systems, when first starting out. [90% of them had to relocate to a new area for this first job.]

* The next most frequent response (20%) was team leading, as most had been educated almost exclusively in primary care in their nursing schools.

* 20% also commented on working and being comfortable with corpsmen as "subordinates" especially ones with more experience on the ward, counselling and disciplining them, and delegating responsibilities.

* Also there were several (15%) comments on the long hours (and "time expected to be in work space on off-duty hours").

* Other miscellaneous comments included:

-"so much information and responsibility at once"

-"adjustment of being a nurse and officer at the same time"

-"dealing with civilian RN's"

-"finding child care"

-"parking and PSD"

3. WHAT OR WHO HAS HELPED YOU THE MOST IN YOUR ADJUSTMENT THESE FIRST 7 MONTHS?

30% indicated their **division officer**

25% indicated family;

25% indicated peers, friends from OIS, staff nurses they work with (peers)

20% indicated their preceptor

15% indicated their clinical consultant

15% indicated their supervisor (department heads)

4. WHAT DO YOU FEEL IS DIFFERENT ABOUT YOUR ROLE AS A NEW NURSE IN THE NAVY VS HAD YOU STARTED IN THE CIVILIAN SETTING?

*70% indicated that the increased responsibility over their civilian counterparts was the main difference; some spoke specifically of responsibility in relationship to increased leadership role and in educating and evaluating others;

*25% indicated collateral duties

*20% commented on more team leading and "desk" work than patient care

*other miscellaneous comments (both positive and negative) included:

-"many more hands-on experiences" (desk, charge, iv's, scheduling)

-"worrying about politics and fitreps"

-"working more hours and increased patient loads"

-"less money"

-"more opportunities to experience different fields, more challenges"

-"less control over my life; less ability to select when I work"

-"respect"

5. DO YOU FEEL WELL PREPARED AS A <u>NEW NURSE</u> FOR THE EXPECTATIONS THAT HAVE BEEN PLACED ON YOU <u>AS A NURSE</u>?

90% indicated YES

10% indicated NO

6. DO YOU FEEL WELL PREPARED AS A <u>NEW OFFICER</u> FOR THE EXPECTATIONS THAT HAVE BEEN PLACED ON YOU AS A <u>NAVAL OFFICER</u>?

70% indicated YES

10% indicated NO

(remainder no comment or neutral opinion)

*(Several comments were made (from both the "yes" and "no" individuals,) indicating a desire to be more militarily "in line" with the LINE, or feelings that their role as an officer

in the medical side was different than Line officers. [I got a sense of some feelings of role ambiguity from these individuals.] In general, the comments were on the positive side about OIS preparing them as well as possible for their "officer" roles.

7. WHICH NURSING ROLE DO YOU FEEL THE MOST COMFORTABLE IN?

[NOTE: These were the responses on the second questionnaire, AFTER 8 months of experience.]

LEAST:		MOST:	
DESK NURSE:	65%	PATIENT CARE PROVIDER:	60%
MED NURSE:	20%	TEAM LEADER	30%
TEAM LEADER:	20%	DESK NURSE	10%
		MED NURSE	10%
		ALL	10%

[NOTE: some indicated more than one "role" in each category of LEAST and MOST.]

The same question was also asked to each participant on the Likert scale from strongly disagree, disagree, neutral, agree, and strongly agree, to get a slightly different perspective with the answers as follows:

"I feel comfortable with the role of patient care provider."

100% indicated agree-strongly agree

"I feel comfortable with the role of medication nurse."

91% indicated agree-strongly agree

"I feel comfortable with the role of team leader."

83% indicated agree-strongly agree

"I feel comfortable with the role of desk nurse."

78% indicated agree-strongly agree.

8. WHAT, IF ANY, EXPECTATIONS HAVE BEEN PLACED ON YOU PROFESSIONALLY THAT YOU FEEL ARE UNREALISTIC OR HAVE OVERWHELMED YOU?

An overwhelming 40% indicated NONE, otherwise very few had anything specific to comment on. There were a few comments on staffing shortages and being spread too thin as a team leader.

The final question, was a chance for the individual to comment on, expand, and make statements on their feelings, conflicts, satisfactions and dissatisfactions with the Navy and with Nursing. I have quoted directly several of the comments.

9. SINCE THIS STUDY IS ON "ROLE CONFLICT" AND ON "REALITY SHOCK" FOR NEW NAVY NURSES, PLEASE FEEL FREE TO MAKE ANY COMMENTS YOU WOULD LIKE TO MAKE ON THESE CONCEPTS IN RELATION TO YOURSELF AND YOUR INITIAL 7 MONTH ADJUSTMENT TO THE NAVY:

*"Switching from my nursing school load of 1-2 patients and making individualized Nursing Care Plans from scratch to being responsible for 15-30 patients on your team and barely having time to see if a STANDARDIZED care plan has been initiated, let

alone if it is being implemented or evaluated."

*"I think the real reality shock is when you go to work everyday and no one comments on your performance or let's you know in writing how you are doing; so you continue to assume that everything you are doing is satisfactory, then the fitness report shows otherwise."

*"Trying to keep up with meds and procedures is challenging and the biggest reality shock."

*"You have to be a self motivated person to be a good Navy nurse... you have to be willing to give a lot of yourself to the Navy."

*"After I received my license as a RN, I felt a let down. I had met all the goals I had set for myself. I do not know what to strive for now. My future as a nurse seems blurry now."

*"Moving to San Diego and having no close family support because of distance"

*"The unit I'm on is so 'user friendly' -- exceptionally supportive and close, so my reality shock may be yet to come when I rotate out."

*"Looking back, it was very hard to adjust to graduating, taking boards, going to OIS, and moving to San Diego, all in a few months--a real 'reality shock'. Since I never met my sponsor, even after I tried to initiate contact at least twice, it was also hard to get adjusted to living and getting around in a big city such as San Diego, as well as a big command."

*"Naval Officer VS RN ... trying to do both well!"

*"My biggest role conflict is between Navy officer and being an INDIVIDUAL (fraternization, my hobbies, and the need to feel I belong to something)."

*"When I got out of Nursing school, I was eager 'to make a difference' and change the world, but I now realize what I learned was ideal and probably won't happen. My nursing school prepared me to do my job as a Nurse; however it didn't prepare me to deal with personalities and co-worker relations."

Many of these comments particularly in question #9 support the literature on the problems caused by reality shock: professional-bureaucratic conflict (being an officer at the same time as being a Navy Nurse especially in a very bureaucratic system), expectations (from Nursing school) VS reality, occupational socialization (status passage).

The remainder of this analysis will focus on the results of the remainder of the questions (obtained from answers using Likert scale) from questionnaires #1 and #2 relating job satisfaction to the other factors examined (role support, role conflict, role overload, and role ambiguity).

To see how the above factors changed over time, a matched T-test comparing identical questions from questionnaire #1 to questionnaire #2 was performed. From Table A only three P-Values came up significant. At a significance where $p < 0.05$, the results showed that over time (eight months), job

TABLE E

COMPARISONS OF ROLE CONFLICT, ROLE OVERLOAD, ROLE AMBIGUITY, ROLE SUPPORT, AND JOB SATISFACTION IN PRIOR-SERVICE NEW GRADUATES AND "MALCONTENTS" TO THE WHOLE GROUP

	WHOLE GROUP		PRIOR SERVICE		TAIL PROBABILITY	WHOLE GROUP		"MALCONTENTS"		TAIL PROBABILITY
	M	SD	M	SD		M	SD	M	SD	
ROLE CONFLICT										
QUESTIONNAIR #1	2.41	0.50	1.58	0.42	0.02*	2.11	0.47	2.33	0.84	0.50
QUESTIONNAIR #2	2.12	0.48	1.61	0.65	0.06(MS)	1.78	0.37	2.22	0.69	0.07(MS)
ROLE OVERLOAD										
QUESTIONNAIRE #1	2.78	0.56	2.61	0.88	0.61	2.85	0.62	2.60	0.68	0.39
QUESTIONNAIRE #2	2.33	0.54	2.17	0.96	0.61	2.21	0.52	2.37	0.81	0.61
ROLE AMBIGUITY										
QUESTIONNAIRE #1	2.33	1.00	1.50	0.58	0.15	2.00	0.93	2.20	1.10	0.73
QUESTIONNAIRE #2	2.50	1.02	1.80	0.45	0.16	2.36	1.12	2.25	0.71	0.80
ROLE SUPPORT										
QUESTIONNAIRE #1	4.00	0.78	4.50	0.45	0.16	4.46	0.42	3.80	0.86	0.046*
QUESTIONNAIRE#2	3.63	0.67	4.25	0.52	0.058(MS)	4.00	0.63	3.60	0.70	0.18
JOB SATISFACTION										
QUESTIONNAIRE #1	4.00	0.57	4.33	1.03	0.36	N.A.	N.A.	N.A.	N.A.	N.A.
QUESTIONNAIRE #2	3.31	0.44	3.40	0.93	0.77	N.A.	N.A.	N.A.	N.A.	N.A.

* indicates significance < 0.05

(ms) indicates marginal significance

NOTE: "N.A." is indicated under Job Satisfaction with the "malcontents," as the basis for placing them in the malcontent category was due to their responses of high job dissatisfaction.

CHAPTER FIVE

Conclusion

Something can be done about the reality shock experienced by nurses on their first job. Our best nurses do not have to flee from nursing practice. We, in nursing, must learn to view and accept conflict as potentially healthy and a way to grow professionally .

Given that conflict in today's ever-changing world is inevitable, and is not necessarily detrimental to productivity and job satisfaction, properly managed, conflict is the avenue needed for social change. Argyris promotes conflict as potentially growth-producing (Hersey and Blanchard, 1988). In resolution, the individual uses behavioral strategies weighing, assessing, and merging the values of both the school and work cultural systems, consciously striving to evolve a cooperative stance in managing the conflict.

It is not enough to identify a problem (the potential conflict faced by professional nurses) and to identify the effects of not solving the conflict (reality shock, job dissatisfaction, and exodus) (Vredenburgh and Trinkaus, 1983; Levinson, 1990; Bacharach, Bamberger, and Conley, 1990). Design and evaluation of potential solutions is mandatory.

There is a tendency of many large professional organizations to direct all their energies toward identifying and attracting new employees, then ignoring them in the first few critical months of

employment. The result is the new employee (and in neophyte nurses interviewed) feels abandoned, confused, often frightened, and terribly helpless -- an employee who begins to question the decision not only to work for that particular organization (in this case, the Navy Nurse Corps), but also question the decision to become a nurse. With the helplessness feelings, come a sense of futility as the option to resign is not there in the Navy.

Despite Kramer's recognition of this problem 18 years ago, it is well documented that the problem of making the transition from student to professional nurse still exists. There is a widespread dissemination and support of findings concerning the new graduate's job dissatisfaction (at the rate of 44% in one study), high turnover (up to 70% in some institutions), burnout, disillusionment, lack of self-assurance, and "reality shock" (Default, 1986). Recognition of the problem has given rise to a multitude of interventions to assist the novice nurse including bicultural training programs (Kramer's method), internships, precepterships, mentors, clinical specialists, and staff counselling specialists.

SUMMARY OF FINDINGS

This descriptive exploratory study looked at the problems of reality shock and role conflicts for new graduate nurses in a highly bureaucratic setting, i.e., the Navy Nurse corps. Following 21 new graduate BSN nurses from 2 weeks after reporting in to their first duty station (Naval Hospital, San Diego) to eight months later, the study looks at the new graduates expectations versus reality, school-

to-work transition problems, dissatisfies and conflicts with both their professional as well as officer roles in the Navy Nurse Corps, and how these decreased, increased and changed throughout this period of time. The information was obtained using two questionnaires and both group and individual interviews two weeks and eight months into their professional adjustment. Specifically the evaluation tools measured over time differences and correlations between job satisfaction and role conflict, role overload, role ambiguity, role support. The results showed the following: (1) over time even though role conflict and role overload decreased, job satisfaction also significantly decreased; (2) the role conflict and role overload that did exist had a significant inverse relationship to the amount of job satisfaction the neophyte perceived (3) role support directly affected job satisfaction; (4) role ambiguity did not have a significant effect on job satisfaction.

The main problems found with this group of neophyte Navy nurses in their school-to-work transition can be summarized as: little or no help from a sponsor (lack of initial support), having 4-8 different preceptors during their first 6 weeks of orientation, lack of feedback during orientation.

Even though this study was with a small group of new graduates (21), the results showed that nearly 50% of them (those placed in the "malcontent" category) did NOT indicate that they were happy being a Navy Nurse and/or were NOT happy with their chosen profession. So I feel, not only does a problem exist, but that it must be re-addressed by the Navy Nurse Corps. The rest of this chapter discusses some of

the above interventions and other possible solutions that could be utilized by the Navy in its attempts to ease the neophyte nurse's transition into the professional world of the Navy Nurse Corps.

SUGGESTED SOLUTIONS

IN THE NURSING SCHOOLS: Kramer's solution for dealing with the professional-bureaucratic conflict starts with the nurses in their nursing training. Many nurses, critical of the training they received, state a desire to have more balance between theoretical (classroom) learning and practical on the job learning. A major source of frustration for new professionals was the conflict between their goals of trying to help patients, and the structures, procedures, and priorities of the organizations that employed them. Kramer developed a course for student nurses in which they were presented with the problems, acted them out, tried to solve them, and then learned how their solutions compared with the "experts" (i.e., experienced staff nurses). Her evaluation data suggested that the training program had a positive impact on the attitudes, motivation, and performance of the nurses when they began practicing (Kramer, 1974).

HOSPITAL STAFF INSERVICE EDUCATION: As a staff educator, I am mostly interested on what interventions can be taken when the new graduate nurse arrives at a Naval hospital facility to work, if earlier (i.e., in nursing school) interventions did not work.

Believing in the concept that **job satisfaction is the result of good work, not the cause of it,** I feel the main solution is to start with the **training in the work place.** If we can help the new nurses do good work, then job satisfaction will result.

The educators in the in-service setting are the normal socializing agents of the work scene; they are usually the first representative of the work system that the neophyte encounters. To them is entrusted the responsibility of explaining and interpreting the system. Not only in terms of orienting new nurses to the various departments and how the equipment works, but more importantly the educators need to help the neophyte develop effective interpersonal strategies so that she can nurse within the system and be a positive influence for changes in the patient care system. Many new nurses receive no formal orientation when they begin first jobs; others attend lecture sessions in which organizational rules and procedures, staff benefits, and other administrative matters are covered. The assumption is that a trained professional need no further introduction to the world of work.

In reality, the inservice orientation may need to take over and familiarize the new graduate with information she should have developed in school. Today's philosophy in the nursing colleges tends to de-emphasize technical skill learning, preferring to emphasize problem-solving and clinical judgement capabilities that will serve their graduates over time, enabling them to continue to learn and solve problems (Horsburgh, 1989). But when the new graduate does not feel competent and cannot demonstrate competence on

basic skills, her effectiveness in every area is likely to suffer. The fact is that basic skills are easiest to observe and assess. Thus the new nurse herself, as well as those around her may take these as indications of overall capability.

Neophyte nurses also need to begin dealing with the conflict and the problems encountered when they work in the real world of nursing in less than ideal circumstances, and in dealing with the care of many patients (versus the "few" they took care of in the school environment).

A learning assessment of each new graduate should be performed by the hospital educators, as well as the head nurse. The closed approach of giving only what information is deemed necessary and important by the hospital with no assessment of the individual learning needs of the orientees, lacks accountability, not only for the new graduate, but for all new employees. Ideally there should be a specialized orientation for new graduates, designed around the general needs of new graduates, as well as for each individual according to their needs. These should include skill labs that include practice in the skills individualizing what they need immediately upon starting to work in their individual unit assignments. For example, IV training and computer training (for all areas), EKG interpretation (if they are going to a critical care unit), triage procedures (if they are going to the emergency room), naso-gastric insertion and Chest tube care (if they are going to Surgical areas), and chemotherapy drug classes (if they are going to oncology.) The main idea is that the orientation should be

customized to what the new nurse feels she needs and according to where her initial assignment is going to be.

NURSING MANAGEMENT: Inservice educators need to work hand-in-hand with management. The orientee's head nurse needs to become knowledgeable of the postgraduate socialization process and the signs and symptoms of the various stages of reality shock. Most important, she needs to learn her own reactions to the conflict experienced by young graduates and ways in which she might constructively manage her feelings in the situation. Studies have shown that the supervisor has a strong effect on the level of stress and motivation experienced by the new professional (Pincus, 1986). Those who made the best career adjustment tended to have supervisors who: set clear goals and direction without becoming overbearing; provided technical advice and coaching to help the novice learn and grow; gave frequent feedback on performance; provided an exemplary role model (committed, calm, positive); and served as an effective buffer between the novice and the organization (Kramer, 1974).

MENTORING: Mentorship may be a powerful administrative tool for retaining and increasing satisfaction in competent nurses. It has the potential of enhancing and enriching nursing career satisfaction by facilitating self-confidence and self-respect (Kinsey, 1990). The concept of mentoring has been around for thousands of years. (In greek mythology, MENTOR was Odysseus's counselor.) In today's organizations, the term "mentor" is generally used to identify a

powerful person who has for whatever reason, singled out a fledgling and decided to provide the guidance and support needed to ensure the fledgling's success. However another mentoring idea that is slowly gaining acceptance, and is more in line with the old Greek mythological concept, is that the mentor did not have power, but did have knowledge. This "traditional" mentoring system, when applied to corporations would have as its major objective the imparting of knowledge and guidance to all new employees, as opposed to the singling out of one or a few for grooming. It is this early nurturing that has the potential for significant bottom-line results.

In the setting of a neophyte nurse in the Navy, the benefits would be:

- Quick group identification and a feeling of belonging to add to the cohesiveness and team potential of the group;

- Maximum productivity will be reached earlier;

- Loyalty and organization commitment will be fostered;

- Identifiable communication channels will ease confusion and allow the channeling of energy to performance;

-Understanding of performance criteria and regular feedback will ensure early job satisfaction;

-Open communication will facilitate quicker learning and growth;

-Promotes career development, career satisfaction and success.

Success of the mentoring system relies heavily on the selection of the person who will fill the mentor role. Interviews with new professionals in Fortune 500 companies, indicate the selected person

should be a peer, with similar academic and work backgrounds. In no case should a supervisor assume the role. It should be someone with at least two years experience at the work locations, and physical placement with, or near the new employee, someone recognized as a good performer, who will present a good image of the corporation. (Bradby, 1990)

With the transient nature of the Navy, mentoring in its ideal form, as described above, may be difficult, but not impossible. It was obvious that with the group of Neophytes used in this study, that the "Sponsor" program often did not work. (57% complained that they either never heard from their sponsor, or that the sponsor was not there to help them in their initial adjustment to the area, to the hospital, and to the Navy.) My suggestion would be to incorporate the sponsorship program with the mentor program. The neophyte may wish to switch (and personally choose) the mentor later especially as she becomes more senior and more adjusted to the bureaucracy of the Navy. But the secret of success of a mentor program is the assignment to the new employee one who will perform the role of friend, confidant, and advisor from a period beginning PRIOR to reporting to work and ending at a time when assimilation has been completed. I see the role in the Navy as follows:

The initial mentor's assignment and primary role would be host and guide, matching them if possible with race, sex, background (married VS single) and would begin with making contact in OIS two to four weeks before they report in to their first duty assignment. Acting as a host for the new Nurse, the mentor should:

BEFORE ARRIVAL:

1. Call the new nurse. Introduce and explain the mentoring function and program (now as our present "sponsor" is supposed to do);

2. If physically possible, arrange to meet the new Nurse and determine her needs before her first day of work to ease the transition;

3. Give any preliminary reading material as introduction to the hospital and department or her new job;

4. Make the "mentoring" role clear in words and spirit (not being overbearing or trying to force the new employee to take help that they feel isn't needed) but at the same time instilling a sense of belonging to the organization.

DURING THE FIRST TWO WEEKS:

1. Familiarize her with the physical setup of the hospital, and to get through the check-in procedures. Assist them in becoming familiar with their geographical location (helping them with finding housing, child-care, banking, etc.);

2. Answer questions and be observant of the new nurse's assimilation;

3. Introducing her to her charge nurse, supervisors and peers;

4. If there is a personality conflict or if a good working relationship has not been established within the first two weeks, the mentor would recommend a change of mentors at this time.

The end of the initial two week period marks the critical juncture in the assimilation process as the new employee goes from the "getting acquainted" stage to the "blending in" stage. At this point the mentor's responsibilities begin to shift from those of a host (or "sponsor") to those of an advisor.

On an ONGOING BASIS, the mentor should:

1. Remain available for questions while encouraging independence;

2. Volunteer information, especially if the neophyte seems reluctant to ask;

3. Introduce her to experts in related work areas and encourage her to interface with them;

4. Explain the military "jargon" when used;

5. Try to expose the neophyte to others in and outside the work group and to other new employees;

6. Keep her informed about meetings she should attend and give pre-meeting and post-meeting analysis;

7. Make her aware of social groups, such as aerobics, bowling and softball teams, officer club, and Junior Nurse Corps activities;

8. Maintain the helper and friend relationship and not seem to be a surrogate supervisor or give the feeling that she is being "checked up" on;

9. Encourage her when her spirits are down; provide needed reassurance;

10. Monitor assimilation and be prepared to sever the "formal" mentoring relationship when appropriate;

I see the mentor as a combination of our current sponsorship program and a person who continues with the socialization process and career grooming-- an intensely personal and emotionally laden relationship in which mentor and protege have enormous energy invested in each other. Mentorship as a resource to aiding career development can strengthen the nursing profession by enhancing retention of competent nurses.

PRECEPTORSHIP: The development of the preceptor model is viewed by many as potentially the most significant and valuable of the sources and programs developed to help the novice's transition into the professional world (Default, 1986). Preceptor programs involve the pairing of the novice nurse with a more experienced staff nurse. While formal orientation classes are provided to new graduates in their command and staff education orientations, this decentralized model of orientation further increases the relevance of new information and provides the setting for guided application. Ideally, the preceptor integrates what the neophyte has learned in school with "reality" in the hospital patient care setting. The preceptor/preceptee relationship provides the novice with a role model who demonstrates a high level of clinical competence, leadership, communication, interest in professional growth, ability to resolve conflict, and willingness, and ability to provide constructive feedback and direction to the novice. As novices increase their clinical skills and grow in self-confidence, the

complexity of patient assignment increases and with anticipatory planning rather than in a crisis-intervention fashion.

One of the main criteria though for making a preceptor program work is the ability of the preceptor to give continuity of instruction and guidance. In the case of the new graduates that I followed 60% of them had four to eight different preceptors during their eight week orientation. [Presently, the preceptors are assigned (not volunteers) by the division officer or department head, and due to frequent schedule changes, classes for the orientee, and efforts to orient the new nurse on all shifts, the orientee seldom follows exactly the preceptor's schedule. This results in multiple people doing the orientation instead of just one.] This is a serious problem that needs to be solved for the program to work and for an effective orientation of new nurses to result.

There must be administrative support (from the Department Heads and Division Heads) for not only scheduling of the preceptor and orientee together, but also for selection of motivated preceptors. To do this, Staff Education needs to communicate openly with the unit administrators, as well as getting them involved in the planning and implementation of an effective preceptor program. There also needs to be a training program for the preceptors to prepare them for their role as well as incentives for them to not only want to BE preceptors, but to be effective and enthusiastic in the job.

I also think there needs to be someone to coordinate the selection of preceptors with the area division heads and department heads, and to monitor and follow all the preceptors and preceptees

through their orientation. This person should have weekly meetings with the preceptor, orientee, and the charge nurse (division head) to discuss behavioral expectations, goals, and any problems. This not only serves as an opportunity for the preceptor to be supported by the educator, but also allows the division head to become involved in the process. This coordinating person could be an educator from the Staff education department assigned to follow all the orientees and their preceptors, or perhaps more realistically it could be the area's clinical consultant, or even the unit's Education officer. As suggested from my surveys and interviews, there is strong desire for more feedback. This is supported by research that finds that **one of the most important job motivators is feedback** (Frase, 1992). With weekly meetings, feedback, both formal (written) and informal (verbal), should be incorporated.

NURSE ADVOCATE OR STAFF COUNSELING SPECIALIST: Besides the aggregate-level stressors common to RNs the new graduate has specific stresses and special needs which compound job dissatisfaction. These factors are not adequately addressed in most existing retention strategies. Neophytes experience feelings of pride, relief, anticipation, an overriding need to be accepted by coworkers, and a fear of being criticized and rejected by experienced RNs. Some new graduate nurses have been in the student role since kindergarten. The sudden prospect of independence generates enormous anxiety and ambivalent feelings of eagerness and dread (Anderson, 1989). At work they are bombarded with seemingly contradictions between the beliefs,

values, and application of skills of those from school and those of the work setting, entering a transitional state of normlessness in which they are neither student nor proficient RN. Some hospitals have now introduced a new position to help the nurses adjust in their first few months to return to a state or normalcy. The job title may be Nurse Advocate (Anderson, 1989) or Staff Counselling Specialist (Tebbin and Pisani, 1984), but the role is created outside the hierarchical line reporting system designed to assist newly employed nurses to adapt more rapidly to the work setting. It addresses group and individual staff concerns and educates staff in effective organizational behavior. In some hospitals, the role is a full time position that also included direct care and consultation with patients and families, and working with staff to cope with death and dying. By being outside the normal chain-of-command, the role is designed to guarantee absolute confidentiality allowing nurses to express concerns and feeling without fear of retaliation. The counselling process is designed to help the nurse clarify personal values and identify specific work-related issues, helping them generate alternatives to problems presented. This is accomplished by spending considerable time encouraging, allowing and supporting staff members in verbalizing their frustrations, thoughts and ideas, clarifying and appropriately confronting issues and perceptions. The job function differs from that of the clinical specialist, who uses these skills to achieve quality care for patients. The Staff Counselling specialist measures success primarily in terms of the nurse's satisfaction.

The new nurses I followed in this study were some of the first in the Navy to have such a resource person available to them. She was a psychiatric nurse, with over 20 years of experience as a Navy nurse, who had established trusting relationships with the staff, and was respected by physicians and Nursing Service department heads. Besides the above qualifications, her interest, commitment, and an ability to relate to the new graduates made her a success in the role. With the support of the nursing administrators and the Staff Education department, she met with all of the orientees (in my group) twice during their first two weeks of orientation (to introduce her role and to begin to establish rapport) and then monthly for the next three months. Although not all of the nurses I interviewed indicated that they sought her out at other times for support or for problems, all were aware of and appreciative of her availability and her role to help them.

SUMMARY OF RECOMMENDATIONS

From the conclusions and summaries of my literature review, and from my own experiences in inservice education departments orienting new graduates I summarize the following recommendations as efforts to ease the transition and decrease the reality shock of new graduates entering the bureaucratic hospital system.

Each nursing inservice education program needs to:

* Individually evaluate the problems of school-to-work transition on an ongoing basis and plan learning experiences to deal with the transition problems encountered;

* Acquaint all new graduate nurses with the socialization cycle and the underlying theoretical perspectives;

* With the help of a seasoned and caring nurse in the role of a Staff Counseling Specialist, develop an awareness and sensitivity for the neophyte to the distorted perceptions likely to occur when the she goes through the shock and rejection phase of reality shock. An increased awareness will not lessen the need for role transformations, but it will allow the neophyte to view this difficult transition period from a much less distorted perspective (Anderson, 1988). Learn ways of helping the neophyte deal with her feelings of victimization so that she can move from this closed, threatened position into an open growing stance (Kramer, 1974);

* Develop a preceptor and mentor program to upgrade the quality or role models who portray growth-producing conflict resolution behavior;

* Assess the learning needs (via a needs and skills assessment tool) to guide the orientation of the new graduate on their first job:

* Design an orientation program specifically for the new graduate, consider their needs as well as the needs of the units where they will be assigned. This program should be designed around a gradual phasing in of responsibilities. The transition from student to professional is extremely stressful and the professional needs time to "learn the ropes." A "levelling" system will not only gradually increase expected skills and responsibilities, but also

will facilitate goal setting, feedback, and a sense of efficacy in a particularly difficult and unrewarding area (Horsburgh, 1989);

* Develop a feedback system that will be started while the new graduate is in formal orientation, and continue it throughout her preceptorship and first year of employment. Increasing feedback of results in the job is another way to enhance motivation and help the neophyte to establish clear-cut socialization goals for herself.

Lastly, I want to say that some responsibility for change needs to be put on the nursing educators in the nursing schools themselves. Nursing education cannot continue to educate nurses for a system of practice that is likely to lead to alienation in the first few months of employment. It is essential for nurse educators to work co-operatively with administration, managers, and clinicians within hospitals to clarify the nature of desirable nursing practice.

SUGGESTIONS FOR FUTURE STUDIES

One of the objectives of this research project was to determine whether there is an inter-role conflict between the role of the nurse and the dual role as an officer. Since I did not survey civilian nurses, there was no way within the scope of this project to make a comparison and to further examine the possible conflict. This would be a suggestion for future studies. Also worth examining would be to survey nurses new to the Navy, but not new to Nursing. With the nursing shortages in the last 5 years, there has been a great

increase in the recruitment of work-force nurses into the military. These nurses come equipped with unique problems and a different type of "reality shock."

APPENDIX A

QUESTIONNAIRE #1

QUESTIONS 1-14, ANSWER BY RATING EACH STATEMENT 0-4

0 = STRONGLY DISAGREE
1 = DISAGREE
2 = NEUTRAL OR NO OPINION
3 = AGREE
4 = STRONGLY AGREE

1. MY RECRUITER PREPARED ME AS WELL AS POSSIBLE FOR WHAT I SHOULD EXPECT IN MY FIRST 2 MONTHS IN THE NAVY (6 WEEKS AT OIS PLUS MY FIRST 2 WEEKS AT THIS COMMAND). _____

2. MY NURSING SCHOOL/COLLEGE PREPARED ME AS WELL AS POSSIBLE FOR WHAT I SHOULD EXPECT FOR MY FIRST JOB AS AN RN. _____

3. I FEEL OVERWHELMED MOST OF THE TIME. _____

4. I FEEL OVERWORKED MOST OF THE TIME. _____

5. I FEEL THE EXPECTATIONS PLACED ON ME AS A <u>NURSE</u> SO FAR ARE TOO HIGH. _____

6. I FEEL THE EXPECTATIONS PLACED ON ME AS A <u>NAVAL OFFICER</u> SO FAR ARE TOO HIGH. _____

7. I WOULD CHOOSE ANOTHER PROFESSION, IF GIVEN THE CHANCE. _____

8. I AM HAPPY BEING A NAVY NURSE. _____

9. I FEEL I HAVE NO CONTROL OVER MY LIFE IN THE NAVY. _____

10. [QUESTION DELETED]

11. I FEEL SUPPORTED BY MY PEERS. _____

12. I AM SATISFIED WITH MY PRESENT WORK ASSIGNMENT. _____

13. MY PERFORMANCE EXPECTATIONS ARE CLEARLY DEFINED TO ME. _____

14. IN GENERAL, I FEEL WELL PREPARED ASSUMING MY ROLE AS A NURSE AND AS AN OFFICER IN THE NAVY. _____

PLEASE ANSWER QUESTIONS 15-32 BY CIRCLING THE FOLLOWING MULTIPLE CHOICE QUESTIONS OR BY ANSWERING "SHORT ANSWER" WHEN APPROPRIATE:

15. WHAT TYPE OF NURSING EXPERIENCE DID YOU HAVE PRIOR TO JOINING THE NAVY?

A. NONE
B. PRIOR CORPSMAN
C. 1 YEAR OR LESS
D. GREATER THAN 1 YEAR

16. DID YOU HAVE ANY PRIOR MILITARY BACKGROUND PRIOR TO STARTING THIS JOB (AND IF SO, INDICATE WHAT KIND AND HOW MANY YEARS)?

17. DID YOU HAVE TO RELOCATE FROM ANOTHER GEOGRAPHICAL AREA TO START THIS JOB? IF SO, FROM WHERE?

18. IF YOU DID HAVE TO RELOCATE, DID YOU HAVE ANY SUPPORT HERE (I.E., FRIENDS FAMILY, PRIOR FAMILIARITY WITH THE AREA)? EXPLAIN.

19. IS YOUR CURRENT AREA OF ASSIGNMENT IN AN AREA THAT YOU REQUESTED OR OF INTEREST ?

20. DO YOU HAVE ANY EXPERIENCE IN YOUR CURRENT AREA OF ASSIGNMENT (AND IF SO, HOW MUCH)?

21. DID YOU HAVE THE ASSISTANCE OF A SPONSOR BEFORE YOUR ARRIVAL (AND IF SO, WAS THE ASSISTANCE HELPFUL)?

22. I FEEL <u>MOST</u> COMFORTABLE WITH THE FOLLOWING ROLE:

A. PATIENT CARE PROVIDER
B. MEDICATION NURSE
C. TEAM LEADER
D. DESK NURSE

23. I FEEL <u>LEAST</u> COMFORTABLE WITH THE FOLLOWING ROLE:

A. PATIENT CARE PROVIDER
B. MEDICATION NURSE
C. TEAM LEADER
D. DESK NURSE

24. I HAVE THE MOST DIFFICULTY UNDERSTANDING THE ROLE OF THE :

A. PATIENT CARE PROVIDER
B. MEDICATION NURSE
C. TEAM LEADER
D. DESK NURSE

25. MY EXPECTATIONS AS A NAVY NURSE ARE REALISTIC FOR MY LEVEL OF PROFESSIONAL EXPERIENCE:

A. MOST OF THE TIME
B. SOME OF THE TIME
C. I ALMOST ALWAYS FEEL OVERWHELMED
D. SOMETIMES I FEEL OVERWHELMED BUT SUPPORT IS USUALLY AVAILABLE

26. MY BIGGEST FEARS OR CONCERNS BEFORE I ARRIVED AT OIS WERE:

27. MY BIGGEST FEARS OR CONCERNS BEFORE I ARRIVED AT MY FIRST DUTY STATION WERE:

28. WHAT HELPED YOU THE MOST IN ADJUSTING TO THE FIRST TWO WEEKS AT YOUR NEW COMMAND?

29. WHAT COULD HAVE BEEN DONE TO HELP YOU MORE IN ADJUSTING TO YOUR FIRST TWO WEEKS AT YOUR NEW COMMAND?

30. WHAT DO YOU FEEL IS DIFFERENT ABOUT YOUR ROLE AS A NEW NURSE IN THE NAVY VS HAD YOU STARTED IN THE CIVILIAN SETTING?

31. DO YOU FEEL WELL PREPARED AS A NEW NURSE FOR THE EXPECTATIONS THAT HAVE BEEN PLACED ON YOU AS A NURSE? (EXPLAIN)

32. DO YOU FEEL WELL PREPARED AS A NEW OFFICER FOR THE EXPECTATIONS THAT HAVE BEEN PLACED ON YOU AS A NAVAL OFFICER? (EXPLAIN)

APPENDIX B

QUESTIONNAIRE #2

QUESTIONS 1-25 ANSWER BY RATING EACH STATEMENT 0 - 4
0 = STRONGLY DISAGREE
1 = DISAGREE
2 = NEUTRAL OR NO OPINION
3 = AGREE
4 = STRONGLY AGREE

1. MY NURSING SCHOOL/COLLEGE PREPARED ME AS WELL AS POSSIBLE FOR WHAT I SHOULD EXPECT FOR MY FIRST JOB AS AN RN. _____

2. I FEEL OVERWHELMED MOST OF THE TIME. _____

3. I RECEIVE ASSIGNMENTS WITHOUT THE MANPOWER TO COMPLETE THEM. _____

4. I OFTEN RECEIVE INCOMPATIBLE REQUESTS FROM 2 OR MORE PEOPLE. _____

5. I FEEL OVERWORKED MOST OF THE TIME. _____

6. I FEEL THE EXPECTATIONS PLACED ON ME AS A NURSE SO FAR ARE TOO HIGH. _____

7. I FEEL THE EXPECTATIONS PLACED ON ME AS A NAVAL OFFICER SO FAR ARE TOO HIGH. _____

8. I WOULD CHOOSE ANOTHER PROFESSION, IF GIVEN THE CHANCE. _____

9. I WORK ON MANY UNNECESSARY THINGS. _____

10. I OFTEN RECEIVE AN ASSIGNMENT WITHOUT ADEQUATE RESOURCES AND MATERIALS TO EXECUTE IT. _____

11. I AM HAPPY BEING A NAVY NURSE. _____

12. I FEEL I HAVE NO CONTROL OVER MY LIFE IN THE NAVY. _____

13. I HAVE TO WORK UNDER VAGUE DIRECTIONS OR ORDERS. _____

14. DELETE

15. I DON'T HAVE TIME TO FINISH MY JOB. _____

16. I FEEL SUPPORTED BY MY PEERS. _____

17. I FEEL SUPPORTED BY MY CHARGE NURSE. _____

18. I FEEL SUPPORTED BY MY AREA SUPERVISOR. _____

19. I HAVE A LOT OF FREE TIME ON MY JOB. _____

20. MY PERFORMANCE EXPECTATIONS ARE CLEARLY DEFINED TO ME. _____

21. MY EXPECTATIONS AS A NAVY NURSE ARE REALISTIC FOR MY LEVEL OF PROFESSIONAL EXPERIENCE. _____

22. I FEEL MY SUPERVISOR'S EXPECTATIONS OF ME AS A NAVY NURSE ARE REALISTIC FOR MY LEVEL OF PROFESSIONAL EXPERIENCE. _____

23. I AM SATISFIED WITH MY PRESENT WORK ASSIGNMENT. _____

24. IN GENERAL, I FEEL WELL PREPARED ASSUMING MY ROLE AS A NURSE AND AS AN OFFICER IN THE NAVY. _____

25. I FEEL COMFORTABLE WITH THE ROLE OF PATIENT CARE PROVIDER. _____

26. I FEEL COMFORTABLE WITH THE ROLE OF MEDICATION NURSE. _____

27. I FEEL COMFORTABLE WITH THE ROLE OF TEAM LEADER. _____

28. I FEEL COMFORTABLE WITH THE ROLE OF DESK NURSE. _____

QUESTIONS 29-37: PLEASE GIVE A SHORT ANSWER OR EXPLANATION

29. FROM QUESTIONS 25-28 ABOVE, PLEASE INDICATE WHICH POSITION ARE YOU THE MOST AND LEAST COMFORTABLE PERFORMING AT THIS TIME:

MOST _____ LEAST _____

COMMENTS:

30. WHAT <u>COULD HAVE BEEN DONE</u> TO HELP YOU MORE IN ADJUSTING TO YOUR FIRST 8 MONTHS AT YOUR NEW COMMAND?

31. WHAT DO YOU FEEL IS DIFFERENT ABOUT YOUR ROLE AS A NEW NURSE IN THE NAVY VS HAD YOU STARTED IN THE CIVILIAN SETTING?

32. DO YOU FEEL WELL PREPARED AS A <u>NEW NURSE</u> FOR THE EXPECTATIONS THAT HAVE BEEN PLACED ON YOU <u>AS A NURSE</u>? (EXPLAIN)

33. DO YOU FEEL WELL PREPARED AS A NEW OFFICER FOR THE EXPECTATIONS THAT HAVE BEEN PLACED ON YOU AS A NAVAL OFFICER?

34. WHAT HAVE BEEN SOME OF THE HARDEST THINGS YOU HAVE HAD TO ADJUST TO IN YOUR FIRST 8 MONTHS AT NAVAL HOSPITAL, SAN DIEGO?

35. WHAT OR WHO HAS HELPED YOU THE MOST IN YOUR ADJUSTMENT THESE FIRST 8 MONTHS?

36. WHAT, IF ANY, EXPECTATIONS HAVE BEEN PLACED ON YOU PROFESSIONALLY THAT YOU FEEL ARE UNREALISTIC OR HAVE OVERWHELMED YOU?

37. SINCE THIS STUDY IS ON "ROLE CONFLICT" AND ON "REALITY SHOCK" FOR NEW NAVY NURSES, PLEASE FEEL FREE TO MAKE ANY COMMENTS YOU WOULD LIKE TO MAKE ON THESE CONCEPTS IN RELATION TO YOURSELF AND YOUR INITIAL 8 MONTH ADJUSTMENT TO THE NAVY:

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